State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 56
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567

APPLICATION FOR CONTINUING MEDICAL EDUCATION WAIVER

Please print or type.
Illegible applications will be returned.

FOR OFFICE USE ONLY

Date Received: _____

Date Application: Approved: _____ **Denied:** _____

Date of Audit: (If applicable) _____

Enforcement Approval: ___Yes ___No Date:_____

Name (first, middle, last):	
Address: **Is this address currently on file with the Medical Board as your official address of record? If not, complete reverse.**	
Telephone Number: **FAX Number (if applicable):**	**Telephone ( )** **FAX ( )**
Reason for waiver: **(Check✓one box only.)**	☐ **Retirement (See reverse for practice restrictions.)** ☐ **Health (Part 2 below to be completed by attending physician.)** ☐ **Undue Hardship (See Part 1 below.)** ☐ **Military Service (Submit proof of service.)**
Social Security Number:	
California Medical License Number:	

If you checked "Retirement" enter date you retired from medical practice:

If you checked a box other than retirement, will you continue to practice in California? ☐ **Yes** ☐ **No**

Part 1. Undue Hardship. Please provide all information requested below.

Explain undue hardship reason(s) here. (Attach additional sheet(s) if necessary.) _____

Part 2. Health. Please provide all information requested below.

Description of illness and explanation as to how the illness interferes with the applicant's ability to obtain Continuing Medical Education. (Attach additional sheet(s), if necessary.) _____

Approximate date illness began: _____ **The illness is: Temporary**_____ **Permanent**_____

If "temporary," approximate date applicant will be able to continue his/her Continuing Medical Education:_____

_____ (_____)_____
Attending Physician's Name **Telephone Number**

_____ _____ _____ _____
Attending Physician's Address **City** **State** **Zip**

I certify under the penalty of perjury under the laws of the State of California, that the information contained in this application, including any supporting documents is true and correct and that I am licensed to practice in the State of California.

_____ _____
Applicant's Signature **Date**

_____ _____ _____
Attending Physician's Signature **Date** **License Number**

CONTINUING MEDICAL EDUCATION WAIVER INFORMATION AND FILING INSTRUCTIONS

Under Title 16 California Code of Regulations section 1339, the Division of Licensing may exempt a licensee from Continuing Medical Education (CME) requirements for retirement, health, military service, or undue hardship. To file for a CME waiver, you must complete the application on the reverse side.

IF YOU REQUEST A CME WAIVER BECAUSE OF RETIREMENT FROM MEDICAL PRACTICE, PLEASE BE AWARE THAT IF APPROVED:

1.You may not routinely engage in the practice of medicine and you will be restricted to the following:

(a) Any examining, treating and prescribing is limited to 20 patient visits annually.

(b) You may prescribe only Schedule IV and V controlled substances (unless otherwise authorized by the Board to prescribe from other schedules). We will notify the Drug Enforcement Administration (DEA) of the restrictions; your DEA Certificate must reflect the above restrictions.

(c) Irrespective of your age, any income derived from the practice of medicine shall not exceed the net annual income allowed for recipients of social security benefits.

Any physician who submits an application for a CME waiver which is denied by the division will become ineligible to renew his or her license to practice medicine unless the physician complies with the provisions of Section 1338 -- Audit and Sanctions for Noncompliance.

IF YOU REQUEST AN EXEMPTION DUE TO MILITARY SERVICE, PLEASE SUBMIT "PROOF OF SERVICE" IN THE MILITARY.

CURRENT MAILING ADDRESS

_____

_____

_____

_____

❒ Check here if this is a change of address so your record can be updated. If this is a U.S. Postal Service, P.O. box, you must list a confidential street address.

All items in this application are mandatory; none are voluntary. This information is requested by the Division of Licensing of the Medical Board of California. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for waiver of the Continuing Medical Education requirements pursuant to Section 1339 of the California Code of Regulations. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental and law enforcement agencies.

Disclosure of your Social Security number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgement or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.